Treating marital violence within intact couple relationships: outcomes of multi-couple versus individual couple therapy

Sandra M. Stith, Eric E. McCollum, Karen H. Rosen, Cynthia J. Thomsen

Published Version Information

Citation: Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. Journal of Marital and Family Therapy, 30(3), 305-318.

Digital Object Identifier (DOI): doi:10.1111/j.1752-0606.2004.tb01242.x

Publisher's Link:
http://onlinelibrary.wiley.com/doi/10.1111/j.1752-0606.2004.tb01242.x/abstract

Treating Marital Violence within Intact Couple Relationships: Outcomes of Multi-Couple versus Individual Couple Therapy

Sandra M. Stith
Eric E. McCollum
Karen H. Rosen

Virginia Polytechnic Institute and State University
Falls Church, VA

Cynthia J. Thomsen.

Northern Illinois University

Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy, 30*, 3, 305-318.

Sandra M. Stith, Ph.D., Eric. E. McCollum, Ph.D., and Karen H. Rosen, Ed.D. Human Development Department, Virginia Tech, Falls Church, VA

Cynthia J. Thomsen, Ph.D., Center for the Study of Family Violence and Sexual Assault, Northern Illinois University.

This project was supported, in part, by a grant from the National Institute on Mental Health: Grant No. 1 R21 MH54613-02A1. An earlier version of this manuscript was presented at the 7th International Family Violence Research Conference, Portsmouth, NH.

Correspondence concerning this article should be addressed to Sandra Stith, Human Development Department, Virginia Tech, 7054 Haycock Rd., Falls Church, VA. 22043. E-mail: sstith@vt.edu

Treating Marital Violence within Intact Couple Relationships: Outcomes of Multi-Couples versus Individual Couple Therapy

Abstract

An experimental design was used to determine outcomes of a domestic violence-focused treatment program for couples that choose to stay together after mild-to-moderate violence has occurred. Forty-four couples were randomly assigned to either individual couple or multi-couple group treatment. Nine couples served as the comparison group. Male violence recidivism rates six-months after treatment were significantly lower for the multi-couple group (25%) than for the comparison group (66%). In contrast, men in the individual couple condition were not significantly less likely to recidivate (43%) than those in the comparison group. Likewise, marital satisfaction increased significantly, and both marital aggression and acceptance of wife battering decreased significantly among individuals who participated in multi-couple group therapy, but not among those who participated in individual couple therapy or the comparison group.

Treating Marital Violence within Intact Couple Relationships: Outcomes of Multi-Couples versus Individual Couple Therapy

Currently, most treatment programs for male domestic violence offenders are psychoeducational, with many having an underlying feminist orientation. Treatment in such programs most frequently takes place in a small group of men who batter[1] (Tolman & Edleson, 1995). Programs vary but tend to take place in either an unstructured group therapy model favored by many clinicians or a feminist power and control model favored by most victim advocates (see Mankowski, Haaken, & Silvergleid, 2002 for further discussion of the distinctions and overlap between these models). The unstructured group psychotherapy model tends to last between 3 months and 18 months depending on the program conditions of court mandate and the feminist power and control model typically lasts 6 months, but can vary depending on state standards and conditions of court mandate.

In a recent study based on a sample of 840 male batterers (210 from each of four different batterer intervention programs), 42% of the men reassaulted their initial or new partners during a 30-month follow-up, according to the female partners' reports (Gondolf, 1998). When reports of physical abuse based on partner reports are considered, successful outcomes typically occur in 50% to 80% of cases (Stith, Rosen, & McCollum, 2002).

Unfortunately, available research on the effectiveness of group treatment for physically aggressive male partners is plagued by a number of methodological problems.

[1] Throughout the review of literature, we have chosen to use the terms selected by the original authors for domestic violence offenders. In some cases the authors use the terms "batterers", in other they use the term "offender" and in others they simply use the term "aggressor" .

First, while treatment seems to be successful for at least half of those men who complete treatment, many studies report that only about one-third of batterers initially assigned to treatment actually complete the program (Babcock & La Taillade, 2000). Also, the definition of successful outcome varies from study to study. Some studies consider reduction in violence as success; others use complete cessation of violent behavior as the criterion for success (Edleson & Tolman, 1992). In addition, the source of outcome data is not consistent. Some studies depend on male self-report, which is problematic since men report considerably less violence than do their partners (Edleson & Brygger, 1986; Jouriles & O'Leary, 1985). Some researchers have tried to address this issue by using police reports as a measure of effectiveness, but these studies tend to underreport repeated violence since only a small percentage of domestic assaults are reported to the police. Studies also differ on the length of follow-up. Given the problematic nature of treatment outcome studies, and the high percentage of men who reoffend after traditional treatment of male offenders, it is clear that no single treatment approach for domestic violence has robust empirical support.

Justification for a Conjoint Couples Treatment Modality

While men's group treatment has been effective with some male offenders, there are a number of reasons why other treatment approaches, including conjoint couples approaches, need to be considered. First, the literature describes negative effects from men's treatment groups for some men (Edleson & Tolman, 1992). Sometimes group members support each other's negative attitudes about women or implicitly or explicitly support a man's use of abusive behavior. Although Tolman's (1990) research indicated that men reported that the group experience was an important ingredient in bringing

about change, some women partners in Tolman's study reported negative group effects. For example, one woman said her spouse came home and told her she should stop complaining because other men beat their wives much worse than he did. In one study, 10% to 15% of female partners reported that their lives had worsened since their male partner began attending a batterer's program (Gondolf, 2002). In another study a significant proportion of female partners reported an increase in verbal abuse since their partners attended the treatment program (Dutton, 1986). The potential for negative male bonding in abuse groups is another potential problem (Hart, 1988).

Furthermore, male batterers are a heterogeneous group (Gondolf, 1988; Saunders, 1992; Stuart & Holtzworth-Munroe, 1995). Holtzworth-Munroe and Stuart (1994) reviewed the batterer typology literature and reported that three descriptive dimensions (severity of marital violence, generality of violence [toward the wife only or toward others as well], and presence or absence of psychopathology/personality disorders) have consistently been found to distinguish subtypes of batterers. They suggest that three subtypes of batterers exist – family only, dysphoric/borderline, and generally violent/antisocial – and that tailoring treatment to each subtype of violent men might improve treatment outcome. Stuart and Holtzworth-Munroe (1995) hypothesize that family-only batterers are likely to be the least violent of the groups and that their violence may be associated with problems such as insecure attachment patterns, mild social skills deficits, and low levels of impulsivity. They further hypothesize that this type of batterer may be the most appropriate for couples treatment:

> *Family-only batterers tend to have stable marriages characterized by relatively high marital satisfaction and a high level of commitment to the*

relationship. Thus, couple therapy may be appropriate if the violence is not severe (independently verified by the female partner) and both partners are highly motivated to improve the relationship. (p. 168)

Thus, there is increasing consensus in the field that all batterers do not need the same treatment. The treatment program described here is limited to one subtype of batterer – the family-only batterer – that is most likely to benefit from couple therapy.

In addition to treating subgroups of batterers differently, there is also reason to include female partners in treatment. Both men and women are often violent in relationships. In fact, most research has found that women initiate and carry out physical assaults on their partners as often as do men (Stith & Straus, 1995). Despite the much lower probability of physical injury resulting from attacks by women, assaults by women are serious, just as it would be serious if men "only" slapped their wives or "only" slapped female fellow employees (Straus, 1993). If reciprocal violence is taking place in relationships, treating men without treating women is not likely to stop the violence. In fact, research has shown that cessation of partner violence by one partner is highly dependent on whether the other partner also stops hitting (Feld & Straus, 1989; Gelles & Straus, 1988). Most importantly, when women use violence in their relationships, they are at greater risk of being severely assaulted by their partners (Feld & Straus, 1989; Gondolf, 1998).

Moreover, while men's treatment groups address men's role in intimate partner violence, they do not address any underlying relationship dynamics that may impact each partner's decision to remain in the violent relationship despite the violence, or that may play a part in maintaining the violence. In a study involving the prediction of mild and

severe husband-to-wife physical aggression with 11,870 randomly selected military personnel, Pan, Neidig and O'Leary (1994) found that marital discord was the most accurate predictor of physical aggression against a partner. For every 20% increase in marital discord, the odds of mild spouse abuse increased by 102% and the odds of severe spouse abuse increased by 183%. Since marital discord is a strong predictor of physical aggression toward a partner, it would seem that failure to address marital problems at some point in the treatment of men and/or women would make it more likely that physical abuse would recur.

Finally, 50 to 70% of battered wives remain with their abusive partners or return to them after leaving a woman's shelter or otherwise separating from them (Feazelle, Mayers, & Deschner, 1984). Failing to provide services to both parties in an ongoing relationship may inadvertently disadvantage the female partner who chooses to stay. Interviews with clients participating in our couples treatment program clarify the importance of including *both* partners in treatment at some point. For example, one male client expressed his view of the strengths and limitations of the men's group:

> *[Men's groups] can't really address relationships because they're only seeing one half of the issue . . . The primary function was to persuade the people to stop [violence] and give them tools to help them do that. However, I mean, that was good, that was right, that's what they should be doing. The other side of that is these people are involved in relationships and there may have been something wrong with the relationship. Yes, it was a bad attribute of the guy's behavior, but there*

was something else there too, and that needs to, at some point be addressed.

A female client who participated in a battered women's support group expressed her perspective on the importance of conjoint therapy:

You go into an isolated group of women. . . . We all talked a lot. But we're just in there supporting each other and saying how wrong [things are]. . . this doesn't feel right, this doesn't feel good. Pointing out the things that aren't right. That escalates . . . It's like they're building each other up. But separately. [The men] are getting support in the [batterer intervention] program to feel better about themselves, maybe to help control the anger. In the women's support group they're getting support to build them up. But what are you doing for the couple? . . . Doing this . . . in a vacuum, for us was not working. I don't know how it can with anyone. Someone just attending the [batterer intervention] program and . . . not having any interaction with the women. It was like one-sided. My going to [victim's support group], I got support there, but when I tried to communicate what I was learning from [it] there was resistance [by my partner]. It was like we weren't in the same show.

The treatment model described in this manuscript was developed in an effort to address the issues raised above. It is intended for a specific group of couples in ongoing relationships where mild-to-moderate violence has occurred and both partners want to end the violence in their relationships.

Controversy Surrounding Conjoint Treatment for Domestic Violence

Despite its promise, considerable controversy continues to surround the use of a systemic perspective in the treatment of spouse abuse (Hansen, 1993; Hansen & Goldenberg, 1993). Some professionals have suggested that systems theory blurs the boundaries between batterer and battered spouse and implies that the victim is "co-responsible" for the assault (Author, 1990). In addition, most batterers begin treatment denying their own responsibility and putting the locus of responsibility, and indeed the locus of control, on the victim (Adams, 1988; Bograd, 1984). Therefore, it is possible that when conjoint therapy is used as the primary treatment approach, partners will come to treatment putting the blame for the problems in the relationship and even the responsibility for the occurrence of violence on the victim. Another serious concern regarding conjoint treatment is the potential for violence to escalate, thereby increasing the danger for the victim. Finally, when couples are seen together the abused spouse may be reluctant to speak freely for fear of retaliatory abuse if she does so (Adams, 1988; Bograd, 1984; Saunders, 1986).

We have taken these important concerns seriously, and have kept them in the forefront of our thinking as we developed the treatment model presented here. We incorporated strategies into the model to decrease the risk of violence, to assure that the victim can speak candidly, and to hold the abuser accountable for his violence.

Therapy Model

The Domestic Violence Focused Couples Treatment Program discussed here integrates several theoretically compatible family therapy models. Solution-focused therapy (de Shazer, 1985; 1991) provides the overall philosophic framework for this

integrated treatment model. However, along with this overarching framework, the treatment model draws upon the theoretical base and therapeutic techniques of narrative approaches (Jenkins, 1990), Bowen Family Systems Theory (Bowen, 1978) and cognitive-behavioral approaches (Saunders, 1989; Tolman & Edleson, 1989). The conjoint portion of the treatment program follows a minimum of six weeks of gender-specific treatment for both partners. The 12-week conjoint couples treatment program includes regular individual meetings with both partners to assess the woman's safety and her comfort in raising important issues in the conjoint sessions. Any indication that risk for violence has increased results in at least temporary suspension of the conjoint counseling until the woman's safety is again assured. For a more complete description of the treatment procedures tested in this study, see Author (2002), Author (2003) and Author (2001).

METHOD

Referral Source for Participants

Participants came to the program through a variety of routes. Extensive contacts with treatment providers in the community were made, resulting in the receipt of approximately 700 telephone inquiries from potential clients. Three hundred and sixty four individuals completed intake interviews, and 89 couples completed the pre-treatment in-person assessment and pre-test instruments. Probation officers referred 35 of these couples (39%). In most of these cases, the court ordered the male client to attend the pre-group male-only batterer intervention program, but the couple chose to participate in the subsequent couples program. All women participated in the couples program voluntarily. Other clients responded to advertisements in local papers offering free couples

counseling for couples in conflictual relationships, or were referred by local domestic violence treatment providers, therapists, or lawyers.

Screening Procedures

Screening took place in two different settings. First, we employed a staff member in a local county domestic violence program to conduct intake interviews with all men coming through the county program. She completed intake interviews with over 200 male clients during the first two years of the study. Most of these clients did not have current partners, and were therefore ineligible for this program. Others indicated that they would be interested in couple's treatment and that their partners would be interested. When our research staff contacted the female partners privately, however, in many cases the male's perception of her interest was inaccurate. Only a few of the 44 couples that eventually participated in our couples counseling program came via this referral route.

Most clients came through the second screening setting, i.e., our own research program office. Private, confidential telephone screening interviews (using the Conflict Tactics Scale, Straus, 1979) were conducted with all potential participants who called our research office after being referred or reading one of our advertisements. We accepted only couples with male-to-female physical abuse. Both partners had to want to participate in couples counseling, and both had to be able to communicate in English. We excluded couples in which the female partner needed medical care for injuries sustained in previous violence couple incidents. We also excluded couples with current problems with substances, those who refused to remove firearms from the home or car, and those who refused to sign a no-violence contract.

Eighty-nine couples completed the in-person two-hour intake interview, which included a variety of pre-test instruments. In all cases, the male and female partners were interviewed separately and completed all instruments in separate rooms. Participants were not paid to complete the intake interview or to complete treatment, but treatment was free and childcare was provided. Forty-four couples participated in at least one session of couple's treatment. Of the 45 couples who completed the intake, but did not begin treatment, 15 of the male partners (33%) were noncompliant with the required pre-group gender-specific intervention program and therefore ineligible for the couple's program; 4 (9%) were excluded for excessive violence or substance abuse; 5 couples (11%) separated or decided to divorce before the treatment began; and 21 couples (46%) were unable to attend due to scheduling problems, or decided that they did not want to participate. No couples were excluded because of unwillingness to sign no-violence contract or to remove guns from the home.

Random Assignment

Once both partners had completed the intake interview and pre-test instruments, project staff determined whether they were eligible to begin treatment. If they were eligible, they were randomly assigned to a treatment group. The first 8 eligible couples were assigned to individual couple therapy where the couple met alone with a co-therapy team. The next 8 couples were assigned to the multi-couple group where 6 to 8 couples met together with three therapists. After the first group was filled, the next 8 couples were assigned to individual treatment, and so on. This random assignment strategy approach was used to insure that groups could be filled and started in a timely manner. However, for practical reasons, random assignment was not applied in creating the

comparison group. The comparison group includes 9 eligible couples that completed pre-tests and follow-up tests, but did not participate in treatment due to scheduling problems.

Completion Rates

Couples were considered to have completed the program if they completed 10 of the 12 couple sessions. Twenty couples were randomly assigned to a 12-week individual couple intervention and began treatment. Fourteen of the 20 couples assigned to individual couple treatment completed the program (70%); 6 couples dropped out (30%). Twenty-two couples were randomly assigned to one of five multi-couple groups and began treatment. Sixteen of the 22 couples completed the multi-couple group treatment (73%); 6 couples dropped out (27%). The rate of treatment completion did not significantly differ for the two groups, χ^2 (1, N = 42) = .04, p > .80.

Therapists

Twenty-four different therapists were involved in the co-therapy teams. Thirteen were graduates and eleven were students in our COAMFTE-accredited Marriage and Family Therapy Master's degree program. Twenty of the therapists were Caucasian, two were African-American and two were Hispanic. Each co-therapist provided treatment in both the individual treatment format and the multi-couple format. In each case, one of the co-therapists was a graduate of the program, and in all cases except two, the co-therapy teams were male-female.

Before providing treatment, every therapist had at least two years of education and clinical supervision in working with couples and, in particular, in working from a solution-oriented perspective. In addition, each therapist participated in an all-day training on the treatment model to be implemented. Each session was videotaped and

each co-therapy team received weekly supervision, based on viewing videotapes, from one of the three project directors. Each of the project directors have advanced degrees in Marriage and Family Therapy, are licensed Marriage and Family Therapists, and have had at least 15 years experience working with couples and families. In addition, they have each had extensive experience in treating domestic violence. During the weekly supervision, supervisors confirmed that the therapists were following the treatment model and helped them to deal with challenges presented by the clients. Project therapists and supervisors also met monthly to discuss challenges and successes in implementing the treatment model.

Description of Participants

Couples participating in the Domestic Violence Focused Couples Treatment program came from all over the Washington, DC metropolitan area, but primarily from the Northern Virginia area. The average age of men in the sample was 38.3 (SD = 11.3) while the average age of the women was 35.6 (SD = 11.3). Thirty percent of the couples reported yearly incomes of less than $20,000, 43% reported that they earned between $20,000 and $40,000 and 27% reported incomes over $40,000. Thirty-three percent of men in the sample reported education of high school or below, 25% reported having some college, and 42% reported that they had a bachelor's degree or higher. For women, 23% reported high school or less, 41% reported some college and 36% reported at least a bachelor's degree. The majority (71%) of participants were Caucasian. Most of the men (90%) and women (57%) were employed full-time.

We compared the three groups on age, income, marital status and education to ascertain whether the groups were equivalent at pre-test. There was a statistically

significant difference only for age. Men in the comparison group (*M* =31.4) were significantly younger than men in the multi-couple group (*M* = 39.6 years); men in the individual couple group were intermediate in age (*M* = 37.6), and did not significantly differ from either of the other groups. Similarly, women in the comparison group (*M* = 31.4) were significantly younger than women in either treatment group (*M*s = 38 and 39.5 years for the individual couple and the multi-couple groups, respectively).

Measures

The self-report measures described below were administered at pre-test, post-test (to members of the two treatment groups only), and at six-month follow-up.

Conflict Tactics Scale, Revised (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The CTS2 is the most widely used measure of partner violence. Three of the CTS2 subscales were used in the present study: Psychological Aggression (8 items; e.g., "My partner called me fat or ugly"), Minor Physical Aggression (5 items; e.g., "My partner pushed or shoved me") and Severe Physical Aggression (7 items; e.g., "My partner used a knife or gun on me"). For the pre-test, participants were asked to report how often their partner had committed each act in the past year (0 = *never*, 1 = *1 time*, 2 = *2 times*, 3 = *3-5 times*, 4 = *6-10 times*, 5 = *11-20 times*, 6 = *more than 20 times*). For the post-test (given at the end of treatment to participants in the therapy groups only) and the follow-up test (given 6 months after treatment ended to all participants), men and women were asked how often their partner had committed each act since the last time they had completed the instrument, using the same response format as in the pretest. Scores were computed by summing ratings of the items comprising each subscale. Reliabilities

(Cronbach's alpha) for each of the three scales and for each of the three assessment periods were acceptable (for men, $.65 \leq \alpha \leq .91$; for women, $.70 \leq \alpha \leq .90$).

Kansas Marital Satisfaction Scale. The Kansas Marital Satisfaction scale (KMSS), consists of 3 items that assess relationship satisfaction. Each item was rated on a scale ranging from 1 (*extremely dissatisfied*) to 7 (*extremely satisfied*). Ratings of the three items were summed to compute a total satisfaction score. Schumm, Nichols, Schectman, & Grisby (1983) report scale reliabilities ranging from .89 to .98 and a test-retest reliability over a 10-week period of .71. In addition, the KMSS was significantly correlated with the Quality of Marriage Index and with the Dyadic Adjustment scale (Schumm, et.al 1983). In the present study, internal consistencies for the scale were high at each assessment (for men, $.94 < \alpha < .99$; for women, $.96 \leq \alpha \leq .98$).

The Inventory of Beliefs about Wife Beating (IBWB; Saunders, Lynch, Grayson, & Linz, 1987) was used to measure participant's beliefs and attitudes about the acceptability of wife beating. It contains 31 items in five subscales: Wife Beating is Justified (e.g. "Episodes of a man beating his wife are the wife's fault."), Wives Gain from the Abuse (e.g. "Battered wives try to get their partners to beat them as a way to get attention from them."), Help Should Be Given (e.g. "Social agencies should do more to help battered women."), the Offender is Responsible (e.g. cases of wife-beating are the fault of the husband."), and the Offender Should Be Punished (e.g. "If a wife is beaten by her husband, she should divorce him immediately."). Each item was rated on 7-point Likert-type scale (1 = *strongly disagree*, 7 = *strongly agree*); responses to 30 of the scale items were summed to compute a total scale score. Reliabilities were acceptable at each scale administration (for men, $.83 \leq \alpha \leq .94$; for women, $.79 \leq \alpha \leq .88$).

FINDINGS

Unless otherwise noted, the effects of treatment on each dependent measure were examined using 3 (treatment group) x 2 (sex) x 2 (time: pretest/follow-up) mixed effects ANOVAs, where the first factor is between-subjects and the other two are within-subjects. When necessary, simple effects analyses and Tukey's HSD tests were used to follow up significant effects. Alpha was set at .05 for all analyses. The number of cases in individual analyses varies due to missing data on the outcome measure of interest.

Pre-treatment Comparisons

We first compared the pretest responses of members of each of the three groups (individual couple therapy, multi-couple group therapy, and comparison) on all outcome variables to determine whether the groups were equivalent at pretest. A multivariate analysis of variance (MANOVA) compared the pretest scores on men and women in each group on marital aggression (the CTS Psychological, Minor Physical, and Severe Physical Abuse scores), marital satisfaction (KMSS scores), and acceptance of wife beating (IBWB scores). At pretest, scores of the couples comprising each treatment group did not differ, F (2, 22) = 0.12, $p > .80$.

Inventory of Beliefs about Wife Beating

We next examined the effect of treatment on participants' beliefs about the acceptability of wife beating as assessed by the IBWB. There was a significant main effect of Sex, F (1, 25) = 10.04, $p < .01$. Women (M = 53.80, SD = 13.74) were less accepting of wife beating than were men (M = 70.59, SD = 22.25). There was also a significant main effect of Treatment, F (2, 25) = 4.55, $p < .05$. However, this was qualified by a significant Treatment x Time interaction, F (2, 25) = 4.10, $p < .05$.

Relevant means are provided in the top panel of Table 1, along with the results of simple effects tests. As can be seen in the table, IBWB scores of participants in multi-couple group therapy decreased significantly over time, whereas scores of participants in the individual couple therapy and the comparison group did not.

The three-way interaction between Treatment, Time, and Sex also approached significance, F (2,25) = 3.27, $p < .06$. Because this effect did not attain statistical significance, post hoc tests were not performed. For descriptive purposes, however, the relevant means are provided in the top panel of Table 2. For men, the pattern was similar to that described above; approval of wife beating decreased substantially in the multi-couple treatment group, but not in the individual couple treatment group or the comparison group. For women, in contrast, approval of wife beating decreased slightly across all three groups. No other effects approached statistical significance (ps > .20).

(Insert Tables 1 and 2)

Marital Satisfaction

The next set of analyses examined changes in marital satisfaction as a function of Treatment. There were significant main effects of both Sex and Time, Fs (1, 34) = 12.12 and 5.05, respectively, $p < .05$. Men (M = 13.28, SD = 4.43) were more satisfied with their marriages than were women (M = 11.09, SD = 3.96), and marital satisfaction was higher at follow-up (M = 13.19, SD = 4.73) than at pretest (M = 11.19, SD = 4.06). However, the main effect of Time was qualified by a significant Treatment Group x Time interaction, F (2, 34) = 4.96, $p < .05$. As can be seen in the second panel of Table 1, scores of those in multi-couple group treatment increased significantly over time, whereas scores of those in the individual couple treatment and comparison group did not.

The pattern of changes in marital satisfaction was similar for men and women, as indicated by the nonsignificant 3-way interaction, F (2, 34) = 1.80, $p > .17$. Nonetheless, for descriptive purposes, the relevant means are provided in the second panel of Table 2. No other effects approached significance (ps > .20).

Marital Aggression

Three types of marital aggression were assessed: self-reported receipt of psychological abuse, minor physical abuse, and severe physical abuse from one's partner. To incorporate type of aggression as a factor in our analyses, we conducted a four-way mixed effects ANOVA 3 (treatment group) x 2 (sex) x 2 (time: pretest/follow-up) x 3 (level of aggression: psychological, minor physical, and severe physical), where the first factor is between-subjects and the others are within-subjects.

There was a marginally significant main effect of Sex, F (1, 23) = 3.21, $p < .09$; women (M = 9.94, SD = 5.49) reported receipt of more marital aggression (averaging across psychological, minor physical, and severe physical abuse) than did men (M = 7.26, SD = 5.08). There were also significant main effects of Time and Type of aggression, F (1, 23) = 4.62, $p < .05$, and F (4, 46) = 61.22, $p < .001$, respectively. These main effects reflect the fact that marital aggression was lower at follow-up (M = 6.79, SD = 5.66) than at pretest (M = 10.41, SD = 5.12), and that levels of psychological aggression were highest (M = 16.62, SD = 6.67), followed by minor physical aggression (M = 9.18, SD = 7.75) and severe physical aggression (M = 3.12, SD = 3.47). However, both of these effects were qualified by significant interactions. First, there was a significant interaction of Time and Treatment, F (2, 23) = 3.63, $p < .05$. Relevant means are provided in the third panel of Table 1. As can be seen in the table, levels of marital aggression decreased

significantly among individuals who participated in multi-couple group, but not among participants in the individual couple treatment and the comparison group. This pattern was similar for men and women, as indicated by the fact that the Time by Treatment interaction was not modified by a higher order interaction with Sex, F (2,23) = 1.04, p > .30. Nonetheless, as before, means are provided in the third panel of Table 2 for descriptive purposes.

The other interaction to achieve statistical significance was the interaction of Time and Type of aggression. Means for this interaction are provided in Table 3. As can be seen in the table, levels of all three types of aggression decreased over time. However, this effect was stronger for psychological aggression and minor physical aggression than for severe physical aggression. This effect was not modified by higher-order interactions with Treatment or Sex (ps > .30), and no other effects approached significance (p > .10).

(Insert Table 3)

Recidivism Rates

Six months after the conclusion of treatment, the female partner in each couple was asked to complete a survey containing the CTS2. Data for three women who were not able to complete the follow-up survey were collected in telephone interviews. Thus, we have 6-month follow-up data from the female partners in all participating couples. Additional recidivism information was collected by telephone interviews with the female partners two years after treatment ended. After two years, we were able to contact 11 (68%) of the 16 women who completed multi-couple group treatment, 8 (57%) of the 14 women who completed individual couple treatment, and 4 (44%) of the 9 women in the comparison group. If the female partners reported any physical aggression by the male

since treatment ended (for the 6-month assessment) or since the prior assessment 6 months after treatment ended (for the 2-year assessment), the male partners were considered to have recidivated. Using this criterion, at 6 months post-treatment those in the comparison group reported a 67% recidivism rate; the rates for the individual couple and the multi-couple treatment groups were 43% and 25%, respectively. Six-month recidivism rates were significantly lower for those who completed multi-couple group than for those in the comparison group, $\phi = .41$, $p < .05$. In contrast, men who participated in individual couple treatment were not significantly less likely to recidivate than those in the comparison group, $\phi = .23$, $p > .25$ (see Table 4).

(Insert Table 4)

At the 2-year assessment, among treated couples (that is, those in individual couple and multi-couple group treatment combined), only one woman reported that her male partner had been violent since the 6-month follow-up, a 6% recidivism rate. In contrast, half the women in the comparison group who were contacted reported a subsequent violent incident (50% recidivism). Thus, based on the women we were able to contact, men who completed treatment were less likely to recidivate at the 2-year follow-up than those in the comparison group ($\phi = .50$, $\underline{p} < .02$). We then undertook a more conservative, intent-to-treat analysis (Fisher, Dixon, Herson, Frankowski, Hearron, & Peace, 1990), assuming that all couples we could not contact had experienced violence. Even using this conservative approach, men who completed treatment were less likely to recidivate than were those in the comparison group ($\phi = .32$, $\underline{p} < .05$).

Finally, we compared 2-year recidivism rates between each treatment group and the comparison group (see Table 4). Using data only from the women we were able to

contact, men who completed individual couples treatment were significantly less likely to recidivate than those in the comparison group, $\phi = .63$, $\underline{p} < .03$. The recidivism rate for men who completed the multi-couple group was lower than for men in the comparison group but the difference only approached statistical significance, $\phi = .45$, $\underline{p} < .08$. Using the intent-to-treat approach for these comparisons yielded similar findings. Assuming that all couples that we could not contact experienced violence, men who completed the multi-couple group were significantly less likely than comparison men to recidivate ($\phi = .39$, $\underline{p} = .05$), and the difference between men who completed individual couple therapy and comparison men approached significance ($\phi = .34$, $\underline{p} < .10$). .

In the 2-year follow-up phone calls, we also ascertained whether each couple was still together. Couples who completed treatment were significantly more likely to be together two years after treatment than were the couples in the comparison group ($\phi = .39$, $p < .05$). Of those contacted, 70% of treatment couples but only 20% of comparison couples were still together.

Several women who reported that they had gotten divorced indicated that the couples counseling program gave them the courage to end the marriage. One woman reported that there was no reoccurrence of violence because the counseling gave her the courage she needed to clearly state that she would not tolerate any further violence. As soon as old patterns that traditionally led to her partner being violent resurfaced, she activated her safety plan before he could escalate. They are currently divorced. One woman reported that the couples counseling program made it possible for her to share custody of their child with her husband after their divorce without ongoing violence. Another woman who reported that she and her husband began multi-couple group

treatment expecting that it would probably not be helpful said, “I was very surprised that he was able to stop being violent—I had always heard that once a man is violent he is always violent. So I am surprised and pleased that he could stop. Now he walks away when he feels himself becoming angry—he hasn’t put a hand on me! We are really happy and our relationship is so much better.”

DISCUSSION

This study compared 30 couples that completed the Couples Treatment Program with 9 couples that completed the pretest and follow-up test but did not participate in the treatment program. Two different treatments were compared. Fourteen couples completed 12 sessions of individual couple treatment along with a minimum of 6-weeks in a gender-specific domestic violence group for men (Individual Couple). Sixteen couples completed 12 sessions of multi-couple group treatment along with a minimum of 6-weeks in a gender-specific domestic violence group for men (Multi-couple Group).

We found that multi-couple group showed positive changes across all 3 dependent variables (marital satisfaction, attitudes about wife beating, and levels of aggression). Neither individual couple treatment nor the non-treated comparison group reported any significant changes in these variables. This strength and consistency of these effects is particularly impressive since the sample sizes were relatively small; this suggests that the treatment effects were quite strong.

We also found that, according to female partner’s reports, men who participated in either of the two couples treatment programs were less likely to recidivate than men in the comparison group at both 6-month and 2-year follow-up points. In fact, at the 2-year follow-up, only one of the 25 women contacted (4%) who participated in either couples

treatment program reported that her partner had been violent since the 6-month follow-up.

The results from this study compare favorably with results reported in the most recent male batterer treatment outcome studies. For example, Gondolf (2000) followed up 618 court-referred male batterers in four cities. According to the women's reports, nearly two thirds of the first-time reassaults occurred in the first six months. At the 15-month follow-up, 38% of the initial victims reported a reassault. At 30 months, 45% of the initial victims reported a reassault. Gondolf also reported that the reassault rates were not significantly different across the four programs, despite differences in program lengths and services.

The strong positive outcomes of the couple therapy treatment approach used in the present study calls into question standards that prohibit the use of couple therapy to treat domestic violence. There is some concern expressed in the literature that treating couples conjointly will lead both partners to consider the victim "co-responsible" for the male partner's violence. The fact that both men and women who completed our treatment reported increased negative attitudes about wife beating, suggests that our treatment did not have this effect.

While both groups of treated couples had lower 2-year recidivism rates than did the comparison group, it is important to discuss possible explanations for the consistently positive results reported by participants in the multi-couple group. While there are certainly scheduling challenges inherent in conducting groups, particularly for couples, qualitative feedback from clients at the end of our treatment indicated that what we termed "group process factors" may make the group experience more powerful than

individual couple treatment. When asked to describe what was most helpful about the treatment at post-test, most of the responses from group members were group process factors. For example, many clients mentioned the importance of hearing the stories of other people struggling with domestic violence as they were. Since marital violence is not a typical topic of social conversation, we suspect that the opportunity to discuss it openly breaks some of the sense of isolation that may come from living with such a secret. Similarly, other clients mentioned the importance of the support and caring that they gave and received from other group members. Another important group process factor was learning from others. Sometimes clients mentioned active learning in which group members gave each other advice. They also described more passive learning that came from observing others working on similar issues. A fourth group process factor we labeled "vicarious communication." Some clients were grateful for the opportunity to have difficult issues broached by others as a way of communicating with their own spouse without the discomfort of doing so directly. Finally, several clients mentioned that it had been useful to them to see other couples make progress in strengthening their relationships.

Conjoint treatment remains a controversial approach to working with couples that have experienced violence. We do not mean to minimize the risks than are inherent in working with violent couples, nor the need for victims to be protected from their abusive partners. At the same time, our work, as well as that of others, suggests that conjoint treatment can be a safe and useful way to help couples that have a history of mild-to-moderate spousal violence and that freely choose to stay together.

REFERENCES

Adams, D. D. (1988). Treatment models of men who batter: A profeminist analysis. In K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 176-199). Newbury Park, CA: Sage.

Babcock, J. C., & La Taillade, J. J. (2000). Evaluating interventions for men whobatter. In J. P. Vincent & E. N. Jouriles (Eds.), *Domestic violence: Guidelines for research-informed practice* (pp. 37–77). London: Jessica Kingsley.

Bograd, M. (1984). Family systems approaches to wife battering: A feminist critique. *American Journal of Orthopsychiatry, 54,* 558-568.

Bowen, M. (1978). *Family therapy in clinical practice.* New York: Jason Aronson.

de Shazer, S. (1985). *Keys to solution in brief therapy.* New York: Norton.

de Shazer, S. (1991). *Putting difference to work.* New York: Norton.

Dutton, D. G. (1986). The outcome of court-mandated treatment of wife assault: A quasi-experimental evaluation. *Violence & Victims, 1*(3), 163–175.

Edleson, J. L., & Brygger, M. P. (1986). Gender differences in reporting of battering incidences. *Family Relations: Journal of Applied Family & Child Studies, 35*(3), 377-382.

Edleson, J. L., & Tolman, R. M. (1992). *Intervention for men who batter: An ecological approach.* Newbury Park, CA, USA: Sage Publications, Inc.

Feazelle, C.S., Mayers, R.S., & Deschner, J.P. (1984). Services for men who batter: Implications for programs and policies. *Family Relations, 33* (April), 217-223.

Feld, S. L., & Straus, M. A. (1989). Escalation and desistance of wife assault in marriage.

Criminology, 27, 141-161.

Fisher, L. D., Dixon, D. O., Herson, J., Frankowski, R. K., Hearron, M. S., & Peace, K. E. (1990). Intention to treat in clinical trials. In K. E. Peace (Ed.). *Statistical issues in drug research and development* (pp. 331-350). New York: Marcel Dekker.

Gelles, R. J., & Straus, M. A. (1988). *Intimate violence.* New York, NY, USA: Simon & Schuster, Inc.

Gondolf, E. (1988). Who are those guys? Toward a behavioral typology of batterers. *Violence and Victims, 3*(3), 187-203.

Gondolf, E. (1998). *Multi-Site Evaluation of Batterer Intervention Systems: A 30-Month Follow-Up of Court-Mandated Batterers in Four Cities.* Paper presented at the Program Evaluation and Family Violence Research: An International Conference, Durham, New Hampshire.

Gondolf, E. (2000). A 30-month follow-up of court-referred batterers in four cities. *International Journal of Offender Therapy and Comparative Criminology, 44,* 111-128.

Gondolf, E. (2002). *Batterer intervention systems: Issues, outcomes and recommendations*. Thousand Oaks, CA: Sage.

Hansen, M. (1993). Feminism and family therapy: A review of feminist critiques of approaches to family violence. In M. Hansen & M. Harway (Eds.), *Battering and family therapy: A feminist perspective* (pp. 54-68). Newbury Park, CA: Sage.

Hansen, M., & Goldenberg, I. (1993). Conjoint therapy with violent couples: Some valid

considerations. In M. Hansen & M. Harway (Eds.), *Battering and family therapy: A feminist perspective* (pp. 82-92). Newbury Park, CA: Sage.

Hart, B. (1988). *Safety for women: Monitoring batterers' programs (manual).* Harrisburg, PA: Pennsylvania Coalition Against Domestic Violence.

Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin, 116*(3), 476-497.

Jenkins, A. (1990). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive.* Adelaide, Australia: Dulwich Center.

Jouriles, E. N., & O'Leary, K. D. (1985). Interspousal reliability of reports of marital violence. *Journal of Consulting and Clinical Psychology, 53*(3), 419-421.

Mankowski, E.S., Haaken, J., & Silvergleid, C.S. (2002). Collateral damage: An analysis of the achievements and unintended consequences of batterer intervention programs and discourse. *Journal of Family Violence, 17*, 167-184.

O'Leary, K.D., Heyman, R.E., Neidig, P.H. (1999). Treatment of wife abuse: A comparison of gender-specific and conjoint approaches. *Behavior Therapy, 30,* 475-505.

Pan, H., Neidig, P., & O'Leary, K. (1994). Predicting mild and severe husband-to-wife physical aggression. *Journal of Consulting and Clinical Psychology, 62*(5), 975-981.

Rosen, K.H., Matheson, J.L., Stith, S.M., McCollum, E.E., & Locke, L.D. (2003).

Negotiated time-out: A de-escalation tool for couples. *Journal of Marital and Family Therapy, 29* (3), 291-298.

Saunders, D. G. (1986). When battered women use violence: Husband-abuse or self-defense? *Violence and Victims, 1,* 47-60.

Saunders, D. G. (1989). Cognitive and behavioral interventions with men who batter: Application and outcome. In P. L. Caesar & L. K. Hamberger (Eds.), *Treating men who batter: Theory, practice, and programs. Springer series: Focus on men* (Vol. 5, pp. 77-100). New York, NY, USA: Springer Publishing Co, Inc.

Saunders, D. G. (1992). A typology of men who batter: Three types derived from cluster analysis. *American Journal of Orthopsychiatry, 62*(2), 264-275.

Saunders, D. G., Lynch, A. B., Grayson, M., & Linz, D. (1987). The inventory of beliefs about wife beating: The construction and initial validation of a measure of beliefs and attitudes. *Violence and Victims, 2*(1), 39-57.

Schumm, W. R., Nichols, C. W., Schectman, K. L., & Grigsby, C. C. (1983). Characteristics of responses to the Kansas Marital Satisfaction Scale by a sample of 84 married mothers. *Psychological Reports, 53*(2), 567-572.

Stith, S.M., Rosen, K.H., & McCollum, E.E. (2002). Domestic Violence, pp. 223-254. In Sprenkle, D.H. (Ed.) *Effectiveness research in marriage and family therapy.* Alexandria, VA. American Association for Marriage and Family Therapy.

Stith, S. M., McCollum, E. E., Rosen, K. H., & Locke, L. D. (2002). Multicouple group treatment for domestic violence. In F. Kaslow (Ed.). *Comprehensive Textbook of Psychotherapy (Vol. 4).* New York: John Wiley & Sons.

Stith, S. M., & Rosen, K. H. (1990). Family therapy for spouse abuse. In S. M. Stith &

M. B. Williams & K. Rosen (Eds.), *Violence Hits Home: Comprehensive treatment approaches to domestic violence.* New York: Springer.

Stith, S. M., & Straus, M. A. (1995). Introduction. In S. M. Stith & M. A. Straus (Eds.), *Understanding Partner Violence: Prevalence, Causes, Consequences, and Solutions* (pp. 1-11). Minneapolis: National Council on Family Relations.

Straus, M. A. (1979). Measuring intrafamily conflict and violence: The conflict tactics (CT) scale. *Journal of Marriage and the Family, 41*(1), 75-88.

Straus, M. A. (1993). Physical Assaults by Wives: A Major Social Problem. *In R. J. Gelles (Ed.), Current Controversies on Family Violence* (pp. 67-87). Newbury Park: Sage Publications.

Straus, M.A., Hamby, S.L., Bony-McCoy, S. & Sugarman, D. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 3, 283-316.

Stuart, G. L., & Holzworth-Munroe, A. (1995). Identifying subtypes of maritally violent men: Descriptive dimensions, correlates and causes of violence, and treatment implications. In S. M. Stith & M. A. Straus (Eds.), *Understanding Partner Violence: Prevalence, Causes, Consequences, & Solutions* (pp. 162-172). Minneapolis: National Council on Family Relations.

Tolman, R., & Edleson, J. L. (1989). Cognitive-behavioral intervention with men who batter. In B. A. Thyer (Ed.), *Behavioral family therapy* (pp. 169-190). Springfield, IL: Charles C. Thomas.

Tolman, R. (1990). *The impact of group process on outcome of groups for men who*

batter. Paper presented at the Paper presented at the European Congress on the Advancement of Behavior Therapy, Paris.

Tolman, R. M., & Edleson, J. L. (1995). Intervention for men who batter: A review of research. In S. Stith & M. Straus (Eds.), *Understanding Partner Violence: Prevalence, Causes, Consequences, and Solutions* (pp. 262-272). Minneapolis, MN: NCFR.

Tucker, L.L., Stith, S.M., Howell, L.W., McCollum, E.E., & Rosen, K.H. (2001). Meta-dialogues in domestic violence-focused couples treatment. *Journal of Systemic Therapies, 19,* 4, 56-72.

Table 1

Mean (SD) Mean (*SD*) Scores on Outcome Variables as a Function of Treatment Group and Time

Dependent variable/ Treatment group	Time		
	Pretest	Follow-up	*F* - value
Acceptance of Wife Beating			
Individual couple	67.50 (12.72)	66.60 (16.10)	0.05
Multi-couple group	61.31 (12.83)	48.73 (9.21)	19.97**
Comparison	68.70 (10.49)	73.60 (22.87)	0.28
Marital Satisfaction			
Individual couple	10.50 (2.99)	11.08 (5.11)	0.22
Multi-couple group	10.22 (3.66)	14.59 (3.25)	17.58**
Comparison	13.83 (5.12)	13.50 (5.85)	0.08
Receipt of Marital Aggression			
Individual couple	8.46 (4.83)	6.22 (5.48)	0.99
Multi-couple group	12.47 (5.36)	5.85 (3.86)	27.05***
Comparison	8.97 (3.81)	10.10 (9.09)	0.72

** $p < .01$ *** $p < .001$

Table 2.

Mean (SD) Scores on Outcome Variables as a Function of Treatment Group, Sex, and Time

Dependent variable/ Treatment group	Sex			
	Male		Female	
	Pretest	Follow-up	Pretest	Follow-up
Acceptance of Wife Beating				
Individual couple	76.40 (27.68)	84.10 (32.17)	58.60 (15.12)	49.10 (15.84)
Multi-couple group	70.62 (14.37)	51.00 (12.12)	52.00 (16.52)	46.46 (11.76)
Comparison	71.00 (13.29)	82.40 (42.07)	66.40 (17.24)	64.80 (21.67)
Marital Satisfaction				
Individual couple	11.17 (4.34)	11.75 (6.45)	9.83 (4.51)	10.42 (5.16)
Multi-couple group	12.56 (4.95)	14.88 (4.62)	7.88 (3.42)	14.31 (3.89)
Comparison	15.00 (5.70)	14.89 (6.01)	12.67 (4.95)	12.11 (6.13)
Receipt of Marital Aggression				
Individual couple	6.78 (5.53)	4.30 (4.48)	10.15 (5.64)	8.15 (8.40)
Multi-couple group	11.11 (5.81)	4.14 (3.53)	13.83 (7.59)	7.56 (6.74)
Comparison	7.73 (4.75)	11.27 (10.12)	10.20 (3.40)	8.93 (9.08)

Table 3

Mean (*SD*) Reported Receipt of each Type of Marital Aggression as a Function of Time

Type of marital aggression	Time		*F*-value
	Pre-test	Follow-up	
Psychological	19.56 (8.51)	13.69 (7.67)	10.54**
Minor physical	7.83 (5.40)	4.29 (5.70)	9.59**
Severe physical	3.85 (3.23)	2.40 (5.11)	2.15

** $p < .01$

Table 4

Percentage of Men Recidivating by Treatment Group

Men's recidivism	Treatment Group		
	Individual Couple	Multi-couple Group	Comparison Group
6 months post-treatment	43% (6/14)	25% (4/16)	67% (6/9)
2 years post-treatment	0% (0/11)	7% (1/8)	50% (2/4)